UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ALASKA

Hand Delivered

KIMBERLY ALLEN, Personal Representative of the ESTATE OF TODD ALLEN, Individually, on Behalf of the ESTATE OF TODD ALLEN, and on Behalf of the Minor Child PRESLEY GRACE ALLEN,

Plaintiffs,

vs.

UNITED STATES OF AMERICA,

Defendant.

Case No. A04-0131 (JKS)

VIDEOTAPED DEPOSITION OF MICHAEL LEVY, MD

Pages 1 - 195, inclusive

Friday, February 24, 2006
2:12 P.M.

Taken by Counsel for Plaintiffs
at
ASHBURN & MASON
1130 West 6th Avenue, Suite 100
Anchorage, Alaska

Page 36

Q. Okay. And is that something that's written about in the literature, that is, subarachnoid hemorrhages being sort of misdiagnosed?
A. We've all -- it's -- it's a point of great concern for all emergency physicians that we might miss that.
Q. Okay. And why is that a point of great concern?
A. Because it's an easy diagnosis to miss.
Q. Okay. And why do you say that?
A. Headaches are very common.
Q. Okay. So headaches are very common and -- well, subarachnoid hemorrhage, is -- is that something that could be potentially fatal?
A. Sure. Yes, it is.
Q. And be fair to say that a small number of people who present with headaches actually have a subar- -- subarachnoid hemorrhage. Is that right?
A. Yes.
Q. Okay. But is it -- is there a statistically significant number of patients who present with headache that actually do have a subarachnoid hemorrhage?
A. Yes.
MR. GUARINO: I guess I'm not sure what you

Page 37

mean by "statistically significant." That -- that has no -- has no legal meaning. It's not defined. I mean --
MS. McCREADY: Well, did you under- --
MR. GUARINO: -- does that mean one percent is enough? Is -- is a half of one percent enough? Is --
MS. McCREADY: Well, that's not my question.
Q. Did you understand my question?
A. I guess I didn't. I thought -- well, you asked me whether some people have that, and I don't think that's what you were asking me about.
Q. Okay. Well, is it -- is it -- are there enough people who present with headaches who have a subarachnoid hemorrhage -- is that -- is that number great enough that it's of concern to emergency room physicians?
A. Any potential disease process that we would have the opportunity to diagnose and the opportunity to miss is a concern to us.
Q. Okay. But specifically with subarachnoid hemorrhages, I mean, is that something that's been a concern within the emergency medical profession for -- is it fair to say a few decades: They might miss that diagnosis?

Page 38

A. Yes.
Q. All right. And is that -- is that something that you have seen written about in the literature?
A. Yes.
Q. Is that something that you actually train -- when you're actually training your emergency room physicians or -- or personnel, is that -- is that something that you have actually discussed with them, that is, the diagnosis of subarachnoid hemorrhage?
A. Yes.
Q. Okay. And what do you generally -- in -- in your training of other physicians or care providers who are working in the emergency room, what -- what, in fact, do you train them -- or how do you train them in terms of making the diagnosis or suspect the diagnosis of a subarachnoid hemorrhage?
A. Well, the first thing is to always be vigilant, that it could be something different. It could be a subarachnoid hemorrhage, if they have a headache.
Q. Okay.
A. So we want to look for a change in the

Page 39

quality or nature of pain, pain that's more severe than what may have been experienced by the person in the past, the classic worst headache of one's life.
Q. And to do that, would you need to take a care- -- careful history of the patient?
A. Yes.
Q. And do you consider that to be the standard of care, that is, that you would take a careful history of a patient who presented with a headache?
A. The -- well, with any patient, we want to have sufficient information from them so we can make a diagnosis.
Q. Okay. So for any patient, would you agree that the standard of care is to take a care- -- careful history so that you can make a diagnosis of the patient?
A. Yes. We always wants to be careful. I mean, that's -- and I guess it just depends. One -- start splitting hairs in terms of how much one has to dress something up to call it a careful history, perhaps --
Q. Sure.
A. -- because in any given situation, a careful history could be a couple words.
Q. Okay. But -- but a -- fair enough. But at

Page 40

least with a patient presenting with a headache, you would want to understand the -- the quality of the pain?

A. Yes.

Q. And the -- the quality and nature of the pain, I think you said. Is that correct?

A. Yes.

Q. And whether or not the pain was more severe than pain they've had before?

A. Yes.

Q. All right. And whether or not, as you said, it could be the worst headache of their life. Is that right?

A. Yes.

Q. And how about the -- would the location of the pain make any difference?

A. The location of the pain I don't believe makes a difference per se.

Q. Okay.

A. Although if it has changed from their typical pain, I'll say, then that would be something a person might want to note.

Q. Okay. And how about the onset of pain? Would that be important?

A. Yes.

Page 41

Q. All right. And why would that be important?

A. The -- a more abrupt onset of pain may mean something a little different than pain that starts more gradually.

Q. Okay.

A. There are exertional headaches, for example, thunderclap headaches associated with sexual activity, those kind of things.

Q. Would you want to know what the patient was doing when the pain began, in addition to the -- whether or not it was abrupt?

A. If the patient stated that they had an abrupt onset of headache, then you might ask what they were doing when it started.

Q. Okay. But would that be something if -- if a patient -- in your practice, if the patient presents with a headache, do you ask them what the onset was and whether or not it was abrupt?

A. Yes.

Q. Okay.

A. What I might say more typically was: Is this one of your typical headaches? Was there anything unusual about the headache?

Q. Sure.

Page 42

A. So I might not say, was it abrupt, was it sudden in onset. It'd be sufficient for me if they said, "This is what I've had before."

Q. Okay. And -- and let me ask you if you -- you've dealt with patients who have chronic pain, I assume --

A. Oh, yes.

Q. -- working in the emergency room?

A. Yes.

Q. Okay. And would the -- is the standard of care different for a patient who has got chronic pain, in terms of taking a history, whether or not that's important?

A. The -- is the standard of care different? The approach to the patient is similar, but it's usually more focused, because typically the patient has had many prior experiences with the emergency department, with the health care system. And so quite honestly one can pretty much move forward and ask if anything has changed or if we're just dealing with the same thing. If they have other concerns, what -- what their main concern for being in the emergency department is on that day.

Q. Sure. If you've got a patient that presents at the emergency room with chronic pain, is

Page 43

one of the first things that you want to know whether or not they're there to get pain medication?

A. Well, that's always in there somewhere, isn't it? But the issue really is: What is it today that makes you want to come to the emergency department? If the issue is pain medication, sure, be upfront and say it. If it's something else, let me know, so I can figure out what it is.

Q. Okay. But you would want to know, with a chronic pain patient, whether or not -- if they're presenting with pain, whether or not that pain is different than what they've before?

A. Yes.

Q. All right. Well, let me ask this: If someone said, you know what, it's really not that important to take a history of the patient who presents in the emergency department with chronic pain, would you agree with that?

A. No.

Q. Would you agree that one of the primary functions of the emergency department in a hospital is to determine if a patient has a condition that's serious, treatable and urgent?

A. Yes.

Q. Okay. And would you agree that one of the